STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	(X2) MULTIPLE CONSTRUCTION (X3)			(3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DUITI DING 00			COMPL	COMPLETED	
		15E594		A. BUILDING			08/28/2012	
			B. WIN		ADDRESS CITY STATE ZID CODE			
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE			
MOON (N.)		OFNITED			136TH ST			
MCGIVIN	EY HEALTH CARE	CENTER	CARMEL, IN 46033					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
F0000								
	This visit was fo	r the Investigation of	F00	00	McGivney Health Care			
	Complaint IN00	-			Centerdoes not believe and do	oes		
	Complaint II too	111031.			not admit that any deficiencies	;		
	G 1: D100	114054 0 1 4 4 4 1			existed, before or after the			
	•	114854 - Substantiated.			survey. McGivney reserves al	I		
	Federal/state def	iciencies related to the			rights to contest the			
	allegation are cit	ted at F223 and F225.			surveyfindings through informa			
					dispute resolution, formaal app			
	Survey dates: A	ugust 27 & 28, 2012			proceedings or any administra			
	Burvey dutes. 11	agast 27 & 20, 2012			or legal proceedings. This pla	n ot		
	T '11' 1	000545			correctionis not meant to establish any standard of care			
	Facility number: 000545				contraact obligatoin or poistion			
	Provider number	:: 15E594			and reserves all rights to raise			
	AIM number: 1	00267350			possible contentions and	un		
					defenses in a ny types of civil	or		
	Survey team:				criminal claim, action or			
	Christi Davidsor	DN TC			proceeding. Nothing containe	d in		
	Cillisti Davidsoi	i, KN-TC			the plan of correction should b	е		
	C 1 . 1				considered as a waiver of any			
	Census bed type				potentially applicable peer rev			
	NF: 28				quality assurance or self critica	al		
	Total: 28				examination privileges which			
					McGivney offers its responses credible allegations of complia			
	Census payor typ	ne:			and plan of correction as part			
	Medicaid: 24	r 			its ongoing efforts to provide	. .		
					quality care to			
					residents.McGivney Health Ca	are		
	Total: 28				Center reserves the right to			
					modify polices and/or procedu			
	Sample: 3				and quality improvement syste			
	Supplemental sa	mple: 1			as necessary to better meet th			
	11	•			needs of the residents and the	•		
	These deficienci	es reflect state findings			facility.			
		•						
	cited in accordar	nce with 410 IAC 16.2.						
	Quality review completed on August 29,							
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	3	TITLE		(X6) DATE	

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/10/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION AND PLAN OF CORRECTION DENTIFICATION NUMBER: 15E594		(X2) MULTIPLE CC A. BUILDING B. WING	00	COMP. 08/28				
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 2907 E 136TH ST CARMEL, IN 46033					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	CORRECTION IN SHOULD BE HE APPROPRIATE)	(X5) COMPLETION DATE		
IAG	2012 by Bev Fa		TAG	DEPICIENCY	,	DATE		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	MNG	00	COMPL	ETED
		15E594	B. WING			08/28/	2012
			B. WING		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIE	R			136TH ST		
MCGIVN	EY HEALTH CARE	CENTER	CARMEL, IN 46033				
				,	L, IIV 40000		
(X4) ID		STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0223 SS=D	483.13(b), 483.1 FREE FROM AE SECLUSION The resident has verbal, sexual, p corporal punishments seclusion. The facility must sexual, or physic punishment, or in Based on interverbacility failed to from mental and facility Licensed #1 and free from another resident allegations of all Findings include The record for From 8/28/12 at 11 Diagnoses included to vascular demodernession. A nurses note, of indicated Reside	3(c)(1)(i) BUSE/INVOLUNTARY Is the right to be free from hysical, and mental abuse, nent, and involuntary not use verbal, mental, cal abuse, corporal involuntary seclusion. It is an are resident was free diverbal abuse from a diverbal abuse from a diverbal abuse from a for two of four facility ouse reviewed. (#F) Resident #F was reviewed	F022		Resident F currently has no re of said event. No other residen were affected by this pracitoe. Nurse in question was immediately placed suspensio and taken off the schedule. O 8/28/2012 said nurse was terminated. Resident F was discharged on 8/29/2012 The Facilities Abuse Policy and Procedure was reviewed. All are responsible to stop abuse report abuse immediately. An a staff in-service was conducted SSD on 8/29/2012 in regards MHCC Abuse Prevention Polic and Procedure. All new employees will receive and be in-serviced on the MHCC Abuse Prevention Policy and Procedupon hire. In the event of any Unusual Occurance, the Administrator will be notified immediately after allegation of abuse occurs. The Administrator designee is the Abuse Investigation Coordinator and	ts the n n staff and all l by to cy se ure	09/27/2012
	of 2/17/12 indic	ed with a last review date ated, "impaired verbal R/T [related to]			be responsible for the oversigl timely reporting any alleded allegations.All allegations will submitted via voicemail throug	be	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			COMPLETED
		15E594	B. WIN			08/28/2012
			D. (111)		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER	8			136TH ST	
	EY HEALTH CARE	CENTER			EL, IN 46033	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	dementia"				the ISDH voicemail reporting system and reviewed per	
					Administrator or designee with	
	A care plan dated with a last review date of 2/17/12 indicated, "limited				each report and then followed	'
					with an email or fax with the fa	ıx
	insocialization	abilities D/T [due to]			confirmation to the ISDH within	n
	inability to recal	1"			24 hrs of alleged	
	_				event.TheQuality Assurance Committee will monitor	
	During the entrance conference on 8/27/12 at 9:30 a.m., the DoN was				compliance of the facility MHC	c
					Abuse Prevention Policy and	
		12 40 5 .2 5 41.111., 4114 25 11 11 415		Procedure for each incident ar	nd	
	abuse that had been reported by staff and investigated for the months of June, July				on a quarterly basis.Complian	ce
					to be obtained by 9/27/2012	
	and August 2012					
	and August 2012	2.				
	On 8/27/12 at 11	:00 a.m., four facility				
		ts involving abuse				
	•	provided by the DoN.				
	unegations were	provided by the Bort.				
	An "Investigativ	e Report for Suspected				
	Abuse, Neglect,	or Unusual Occurrence				
	(sic)," dated 6/27	7/12 at 7:10 p.m.,				
	indicated, Reside	ent #F was hit by her				
	roommate. The	report indicated Resident				
		ved and indicated,				
		es roommate (sic) was				
		struck her. Resident				
	_	nine where she had been				
		d no reddned (sic) areas				
		roommate] was upset				
	regarding incont					
		_				
		.Res [resident] stated 'I				
		nt was assessed" The				
	-	there were no other				
	witnesses and th	e residents were				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		15E594	B. WIN	G		08/28/2012	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
M 0 0 1 / 1		OFNITED			136TH ST		
MCGIVNEY HEALTH CARE CENTER			CARME	EL, IN 46033			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	COMPLETION DATE	
IAG	separated.	ESC IDENTIFY THO IN ORMATION)		TAG	,	DATE	
	separated.						
	During the initial tour on 8/27/12 at 9:35						
	_	F did not have the					
	· ·	in the abuse allegation,					
	dated 6/27/12.	in the douse diregation,					
	dated 0/27/12.						
	An "Investigativ	e Report for Suspected					
		or Unusual Occurrence					
		0/12 at 6:00 p.m.,					
	indicated, "Name of Resident(s):						
	[Name of Resident #F]Resident was						
	-	at a separate table in the					
		n for and] was positioned					
		after warning the resident					
		t sit down that she would					
		[name of Resident #F]					
		irse was mean and made					
	her sit at the tabl	e [sign for with] people					
		themselves [sign for and]					
	also later made h	ner sit by herself facing					
	the wallThe nu	irse was suspended					
	during the invest	igation"					
	A handwritten st	atement, included in the					
	investigation for	the incident, dated					
	8/20/12 involvin	g Resident #F, dated					
	8/23/12 and sign	ed by CNA #2 indicated,					
	"On Monday Au	gust 20 during dinner I					
	witnessed the ch	arge nurse yell at and					
	count to 3 for [na	ame of Resident #F] to sit					
	down. She told	[name of Resident #F]					
	that if she didn't	sit down by the time she					
	got to 3 she was	going to sit in the					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E594		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/28/2012	
	PROVIDER OR SUPPLIEI		STREET A 2907 E	ADDRESS, CITY, STATE, ZIP CODE 136TH ST EL, IN 46033	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL ILSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
		ge nurse sat her in the e wallbut the nurse			
	untimed, include the incident date Resident #F was statement indica told Resident if have to sat (sic) residentthe nu	tatement undated, ed in the investigation for ed 8/20/12 involving is signed by CNA #3. The lated, "the nurse then she gets up again she will with the feed rise put her at the feed made her sit alone and			
	with the typed n in the investigat 8/20/12 involvir the LPN's recall at 4:30 p.m. The "Never once we sit anywhere other seatingAgain so by staff. This or and she would be asked to sit down back in the dinner cart, [name of R into the room and no, and reminded there momentary of Resident #F]	tatement, dated 8/23/12, ame of LPN #1, included ion for the incident dated ag Resident #F indicated of August 20, 2011(sic) to estatement indicated, was the resident forced to her than her choice of she was asked to sit down only lasted a few minutes the up againShe was again repeatedlyOnce ing (sic) room at the med the esident #F] again came and asked for a chair. I said down the nurses would be ally to give report. [name directed her attention to hember] and asked her,			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		15E594	B. WIN	G		08/28/2012	
NAME OF P	PROVIDER OR SUPPLIER	\ \			ADDRESS, CITY, STATE, ZIP CODE		
			2907 E 136TH ST				
MCGIVN	EY HEALTH CARE	CENTER	CARMEL, IN 46033				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	[name of staff member] had just arrived						
		she had been told no					
	1	to pull the chair into the					
	_	in a higher than normal					
		stration says (sic) 'No,					
	l - ·	were told no chair until					
	*	I agreed to give report					
	_	thinking that I was the					
	one her behavior						
	towardsAt that	time I left the property."					
	A Facility Incide	ent Report indicated,					
	"Incident Date	: 08/20/12Resident					
	Name: [Residen	t #F]Staff Involved:					
	[LPN #1]Repo	rted that nurse sat					
	resident down in	dining room in a chair					
	by herself facing	the wall after resident					
	had many reques	st for various					
	thingsResident	states nurse was mean to					
	herThe nurse h	as not worked since (sic)					
	the date of the in	cident allegedly occurred					
	and has been sus	spended pending					
	investigationT						
	_	late of 08/28/12[an x					
		ox for] Follow-up					
	Report"	J					
	•						
	During an interv	iew on 8/27/12 at 11:40					
	_ ~	dicated, LPN #1 would					
	l '	sed on the results of the					
		tion. The DoN indicated					
		work any other shifts past					
		e left the building.					
	0/20/12 WHOH SH	o for the building.					

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PRINTED: 09/10/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE S COMPL		
ANDILAN	or correction	15E594		LDING		08/28/	
		102001	B. WIN			00/20/	2012
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
MCGIVN	EY HEALTH CARE	CENTER			EL, IN 46033		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE!		DATE
		provided by the DoN on					
		o.m., titled, "MHCC					
	_	th Care Center] Abuse edure (June 2012),					
	-	y: It is the mission of					
	· ·	ovide its residents with a					
		t environment in which to					
	-	will not tolerate verbal,					
	_	r physical abuse, corporal					
	-	ivoluntary seclusion, nor					
	_	staff member to punish a					
	_	me during a resident's					
	stay in this facili	_					
	-	Resident to resident					
	-	thout injuryVerbal					
	Abuse-is defined						
	residentsMenta	· ·					
		.humiliationthreats of					
	punishment"						
	This Federal tag	relates to Complaint					
	IN00114854.	-					
	3.1-27(a)(1)						
	3.1-27(b)						

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		IDENTIFICATION NUMBER: 15E594	A. BUILDING B. WING	00	COMPLETED 08/28/2012		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2907 E 136TH ST CARMEL, IN 46033				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E594			(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/28/2012	
		10000	B. WING		00/20/20 12	
	ROVIDER OR SUPPLIER EY HEALTH CARE		2907 E	ADDRESS, CITY, STATE, ZIP CODE 136TH ST EL, IN 46033		
(VA) ID	CUMMADVC	TATEMENT OF DEFICIENCIES	I ID		(V5)	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	(X5) COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	483.13(c)(1)(ii)-(ii INVESTIGATE/R ALLEGATIONS/II The facility must in have been found neglecting, or mis court of law; or have been found neglecting, or mis court of law; or have been found neglecting, or mis appropriation any knowledge it law against an enindicate unfitness or other facility staregistry or licensii. The facility must or violations involving and misappropriation are reported immediate and misappropriation are reported immediate and misappropriation are reported immediately expenses. The facility must be stated with a state survey and the state survey are reported to the according to the state survey are reported to the according and misappropriation are reported to the according and potential abuse with the state survey are supported to the according and potential abuse with the state survey are reported to the according and misappropriations investigated, and potential abuse with the state survey are reported to the according and misappropriations investigated representations in according to the state of the	i), (c)(2) - (4) EPORT NDIVIDUALS not employ individuals who guilty of abusing, streating residents by a law had a finding entered se aide registry concerning instreatment of residents or of their property; and report has of actions by a court of inployee, which would it for service as a nurse aide aff to the State nurse aide ing authorities. The sensure that all alleged ing mistreatment, neglect, or injuries of unknown source ition of resident property ediately to the ine facility and to other ance with State law ed procedures (including to land certification agency). The sensure that all alleged in the facility and to other ance with State law ed procedures (including to land certification agency). The sensure that all alleged in the facility and to other ance with State law ed procedures (including to land certification agency). The sensure that all are thoroughly must prevent further while the investigation is in the sentative and to other ance with State law		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)	TE	
	the incident, and verified appropria be taken.	if the alleged violation is te corrective action must ew and record review, the	F0225	Resident C, D, and F currently	09/27/2012	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIWINDING	COMPLETED	
		15E594	A. BUILDING B. WING	00	08/28/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEI	R			
MCGIVN	EY HEALTH CARE	CENTED	2907 E 136TH ST CARMEL, IN 46033		
	LITILALITICANL	CENTER			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG		5.112
	_	report an allegation of		have no recall of said event.N	
	staff to resident	abuse and an allegation of		other residents were affected by this practice. The Nurse in	
	resident to resid	ent abuse immediately to		question was immediately pla	ced
	the Administrate	or and to the state agency,		on suspension and taken off	
	ISDH [Indiana S	State Department of		schedule. On 8/28/2012 said	
	Healthl, for 2 of	4 facility allegations of		nurse was terminatedResiden	
	- ·	reviewed. (Residents #C,		was discharged on 8/29/2012	The
	#D, #F)	reviewed. (residents #e,		Facilities Abuse Policy and Procedure was reviewed. All	otoff
	$\begin{bmatrix} \pi D, \pi \Gamma \end{bmatrix}$			are responsible to stop abuse	
	Findings include:			report immediately. An all staff	
				in-service was conducted by \$	
				on 8/29/2012 in regards to MH	
	1. During the er	ntrance conference on		Abuse Prevention Policy and	
	8/27/12 at 9:30 a	a.m., the DoN was		Procedure All new employees	will
	requested to pro	vide any allegations of		receive and be in-serviced on	
	abuse that had b	een reported by staff to		MHCC Abuse Prevention Poli and Procedure upon hire.In the	
	the Administrate	or and investigated for the		event of an Unusual Occurant	
		July and August 2012.		the Administrator will be notified	
	inomino or vane,	vary and ragust 2012.		immediately after allegation of	
	On 8/27/12 at 1	1:00 a.m., four facility		abuse occurs.The Administrat	or
		_		or designee is the Abuse	
	_	ts involving abuse		Investigation Coordinator and	
	allegations were	provided by the DoN.		be responsible for the ovesigh timely reorting any alleged	TO T
				allegation.All allegations will b	e
	An "Investigativ	re Report for Suspected		submitted via voicemail through	
	Abuse, Neglect,	or Unusual Occurrence		the ISDH voicemail reporting	,
	(sic)," dated 8/2	0/12 at 6:00 p.m.		system and reviewed per	
	indicated, "Na	me of Resident(s):		administrator or designee with	
	[Name of Reside	ent #F]Resident was		each report and then followed	
	_	at a separate table in the		with an email or fax confirmati to the ISDH within 24 hrs. of	Off
	dining room [sign for and] was positioned to face the wall after warning the resident that if she did not sit down that she would			alledged eventthe Quality	
				Assurance Committee will	
				monitor compliance of the fac	lity
				MHCC Abuse Prevention Poli	·
		[name of Resident #F]		and Procedure for each incide	ent
		urse was mean and made		and on a quarterly	d
	her sit at the tab	le [sign for with] people		basis.Compliance to be obtain	leu

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E594		A. BUILDING	CONSTRUCTION 00	COM	TE SURVEY MPLETED 28/2012	
	PROVIDER OR SUPPLIER		2907	T ADDRESS, CITY, STATE, ZIP C E 136TH ST		20/20 12
MCGIVN	EY HEALTH CARE	CENTER	CAR	MEL, IN 46033		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE ADEPICIENCY)	HOULD BE	(X5) COMPLETION DATE
	also later made h	themselves [sign for and] her sit by herself facing hrse was suspended higation"		by 9/27/2012		
	investigation for 8/20/12, involvin 8/23/12 and sign "On Monday Au witnessed the ch count to 3 for [na down. She told that if she didn't got to 3 she was cornerthe charge	atement, included in the the incident, dated ag Resident #F, dated ed by CNA #2 indicated, gust 20 during dinner I arge nurse yell at and ame of Resident #F] to sit [name of Resident #F] sit down by the time she going to sit in the ge nurse sat her in the e wallbut the nurse				
	untimed, include the incident, date Resident #F was statement indica told Resident if s have to sat (sic) residentthe nur	atement undated, d in the investigation for ed 8/20/12, involving signed by CNA #3. The ated, "the nurse then she gets up again she will with the feed rise put her at the feed made her sit alone and				
	with the typed not in the investigati	atement, dated 8/23/12, ame of LPN #1, included on for the incident dated g Resident #F indicated				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 25RM11

Facility ID: 000545

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/10/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE		
		A. BUI	LDING	00	COMPL		
15E594			B. WIN			08/28/	2012
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
MCGIVNEY HEALTH CARE CENTER					136TH ST EL, IN 46033		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		of August 20, 2011(sic)					
	•	e statement indicated,					
		as the resident forced to					
	<u> </u>	er than her choice of					
	"	he was asked to sit down					
	1 -	aly lasted a few minutes					
		e up againShe was					
		n again repeatedlyOnce					
		ng (sic) room at the med					
	cart, [name of Resident #F] again came						
	into the room and asked for a chair. I said						
	no, and reminded her nurses would be						
	there momentarily to give report. [name						
	of Resident #F] directed her attention to						
	[name of staff m	ember] and asked her,					
	[name of staff m	ember] had just arrived					
	and didn't know	she had been told no					
	chair; she began	to pull the chair into the					
	hall. I did speak	in a higher than normal					
	voice due to frus	tration says (sic) 'No,					
	pauses No, you v	were told no chair until					
	report was over.'	I agreed to give report					
	over the phone, t	thinking that I was the					
	one her behavior	was directed					
	towardsAt that	time I left the property."					
	A Facility Incide	ent Report indicated,					
	"Incident Date	: 08/20/12Resident					
	Name: [Residen	t #F]Staff Involved:					
	[LPN #1]Repo	rted that nurse sat					
		dining room in a chair					
		the wall after resident					
	had many reques						
		states nurse was mean to					
	l						

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Event ID: 25RM11

Facility ID: 000545

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	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 15E594	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMI	E SURVEY PLETED 8/2012		
	PROVIDER OR SUPPLIER JEY HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2907 E 136TH ST CARMEL, IN 46033					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	herNurse has not worked since the date of the incident allegedly occurred and has been suspended pending investigation. This was not reported to the DON until 08/23/12. The staff member was immediately inserviced about reporting immediately to supervisor and inservice is set up for staff" 2. An "Investigative Report for Suspected Abuse, Neglect, or Unusual Occurrence (sic)," indicated, "Date and Time of Occurrence: July 18, 2012 12:00 noon Reported July 20, 2012 [sign for at] 7:30 a.m. by family. Name of Resident(s): [Resident #C]Interview with Witness [name of CNA #4] -[Resident #D] swatted no contact" A handwritten statement signed by CNA #4 indicated she was present in the dining room on July 18 and overheard Resident #D tell Resident #C she was going to slap her. During an interview on 8/27/12 at 11:40 a.m., the DoN indicated the facility staff had been retrained and inserviced on the importance of reporting all incidents of abuse and all allegations of abuse immediately. The DoN indicated the incident which occurred on 8/20/12 was not reported to ISDH until 8/24/12. The DoN indicated the incident was reported,						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/10/2012 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER MCGIVNEY HEALTH CARE CENTER XAJI D SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) "a little over 24 hours" from when she was made aware of the incident on 8/23/12. An ISDH incident report form accompanied the investigation from the July 18, 2012 incident, but there was not a time or date to verify when it was reported to the state agency. During an interview on 8/28/12 at 9:30 a.m., the DoN indicated that ISDH had never received the report of the incident from 8/20/12 that was indicated by the DoN as reported on 8/24/12. The DoN did not have documentation of a fax transmittal on either of the above incidents that were indicated as reported to ISDH. The DoN indicated an information technologist would evaluate the facility fax machine. The incident from 8/20/12 was sent via telephone with ISDH staff on 8/27/12 and resubmitted via fax on 8/28/12 after two	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	(X3) DATE COMPL		
NAME OF PROVIDER OR SUPPLIER MCGIVNEY HEALTH CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) "a little over 24 hours" from when she was made aware of the incident on 8/23/12. An ISDH incident report form accompanied the investigation from the July 18, 2012 incident, but there was not a time or date to verify when it was reported to the state agency. During an interview on 8/28/12 at 9:30 a.m., the DoN indicated that ISDH had never received the report of the incident from 8/20/12 that was indicated by the DoN as reported on 8/24/12. The DoN did not have documentation of a fax transmittal on either of the above incidents that were indicated as reported to ISDH. The DoN indicated an information technologist would evaluate the facility fax machine. The incident from 8/20/12 was sent via telephone with ISDH staff on 8/27/12 and								
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evaluate the facility fax machine. The incident from 8/20/12 was sent via telephone with ISDH staff on 8/27/12 and		transmitted to IS	DH. The DoN indicated					
incident from 8/20/12 was sent via telephone with ISDH staff on 8/27/12 and								
telephone with ISDH staff on 8/27/12 and			•					
I resubmitted via fax on 8/28/12 after two		•						
			fax on 8/28/12 after two					
attempts.		attempts.						
A Communication Result Report dated		A Communication	on Result Report dated					
8/28/12 at 8:29 a.m., indicated 3 pages			-					
were sent with result "ok" to ISDH.			, ,					
		or some with it						
A facility policy provided by the DoN on		A facility policy	provided by the DoN on					
8/27/12 at 1:25 p.m., titled, "MHCC			-					
[McGivney Health Care Center] Abuse		_						
Policy and Procedure (June 2012),			=					

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Event ID: 25RM11

Facility ID: 000545

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		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING COMPLETE					
15E594			B. WING	G		08/28/	2012
NAME OF PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					136TH ST		
MCGIVN	EY HEALTH CARE	CENTER		CARME	EL, IN 46033		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	indicated, "Policy: It is the mission of						
		ovide its residents with a					
		t environment in which to					
		will not tolerate verbal,					
		r physical abuse, corporal					
	_	voluntary seclusion, nor					
	1	staff member to punish a					
		me during a resident's					
	stay in this facili						
	Abuse-includes,Resident to resident						
	abuse with or without injuryVerbal						
	Abuse-is defined asbelittling						
	residentsMental						
	Abuse-includeshumiliationthreats of						
	punishmentAll staff are to immediately						
	stop abuse. Immediately report all all						
	(sic) alleged viol	ations involving					
	mistreatment, ne	glect, or abuseare					
	reported immedi	ately to the Charge					
	Nurse. The Char	rge Nurse is to					
	immediately report abuse to the DONThe DON immediately reports all						
	violations to adn	ninistrator of the facility					
	and to other officials in accordance with						
	State lawMHC	C					
	Administrator/de	esignee will be					
	responsible to co	omplete a REPORTABLE					
	-	CURRENCE (sic) form					
		of occurrence and send to					
	the ISDH all alle	eged violations and all					
		idents to the state agency					
		gencies as required"					
	This Federal tag	relates to Complaint					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/10/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E594		A. BUILDING	00	COME	PLETED 8/2012			
NAME OF PROVIDER OR SUPPLIER MCGIVNEY HEALTH CARE CENTER			B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2907 E 136TH ST CARMEL, IN 46033					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE		
	IN00114854. 3.1-28(c)							

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